IN THE COURT OF THREE JUDGES OF THE REPUBLIC OF SINGAPORE

[2018] SGHC 253

Originating Summons No 1 of 2018

In the matter of Section 55(1) of the Medical Registration Act (Cap 174, 2014 Rev Ed) and Order 55 of the Rules of Court (Cap 322, Rule 5, 2014 Rev Ed)

And

In the matter of a Singapore Medical Council Disciplinary Tribunal Inquiry against Dr Wong Meng Hang

Between

WONG MENG HANG

… *Appellant*

And

SINGAPORE MEDICAL COUNCIL

… *Respondent*

Originating Summons No 2 of 2018

In the matter of Section 55(1) of the Medical Registration Act (Cap 174, 2014 Rev Ed) and Order 55 of the Rules of Court (Cap 322, Rule 5, 2014 Rev Ed)

And

In the matter of a Singapore Medical Council

Disciplinary Tribunal Inquiry against
Dr Zhu Xiu Chun @ Myint Myint Kyi

Between

SINGAPORE MEDICAL COUNCIL

… *Appellant*

And

ZHU XIU CHUN @ MYINT MYINT KYI

… *Respondent*

Originating Summons No 3 of 2018

In the matter of Section 55(1) of the Medical Registration Act (Cap 174, 2014 Rev Ed) and Order 55 of the Rules of Court (Cap 322, Rule 5, 2014 Rev Ed)

And

In the matter of a Singapore Medical Council Disciplinary Tribunal Inquiry against
Dr Wong Meng Hang

Between

SINGAPORE MEDICAL COUNCIL

… *Appellant*

And

WONG MENG HANG

… *Respondent*

JUDGMENT

[Professions] — [Medical profession and practice] — [Professional misconduct]

Wong Meng Hang
v
Singapore Medical Council and other matters

[2018] SGHC 253

Court of Three Judges — Originating Summons No 1, 2 and 3 of 2018
Sundaresh Menon CJ, Andrew Phang Boon Leong JA and Judith Prakash JA
4 September 2018

23 November 2018

Sundaresh Menon CJ (delivering the judgment of the court):

1 These appeals concern two doctors at an aesthetic clinic who administered a potent sedative to a patient during a liposuction procedure despite lacking the necessary training or expertise to do so. They then failed to adequately monitor the patient during and after the procedure. This led to the death of the patient. Each doctor pleaded guilty to a charge of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) on the basis of an agreed statement of facts relevant to his or her case.

2 Dr Wong Meng Hang ("Dr Wong"), the doctor who carried out and was in charge of the procedure, was sentenced by the Disciplinary Tribunal ("DT") to 18 months' suspension from practice. The DT sentenced Dr Zhu Xiu Chun @ Myint Myint Kyi ("Dr Zhu"), the assisting doctor, to six months' suspension from practice.

3 Originating Summons No 1 of 2018 ("OS 1") is Dr Wong's appeal against his sentence. Originating Summonses Nos 2 and 3 of 2018 ("OS 2" and "OS 3") are appeals by the Singapore Medical Council ("the SMC") against the sentences imposed by the DT on Dr Wong and Dr Zhu respectively.

4 We state at the outset that this was among the most egregious cases of medical misconduct we have come across. In this judgment, we set out the appropriate sentencing approach in disciplinary cases involving serious professional misconduct by doctors that results in harm to patients, and apply this to consider the sentences imposed by the DT on Dr Wong and Dr Zhu. In particular, we highlight the importance of sentencing considerations such as general deterrence and the need to uphold public confidence in the medical profession, which might in certain cases be sufficiently compelling to override any personal mitigating circumstances that may be found to exist. We also lay down the relevant principles that should guide courts and tribunals when considering whether an order striking the errant doctor off the register may be the appropriate punishment. Further, we make some observations on the relevance of dishonesty in this context.

Background

Events of 30 December 2009

5 Dr Wong and Dr Zhu were registered medical practitioners practising at an aesthetics clinic known as Reves Clinic. On 30 December 2009, Dr Wong was scheduled to perform a liposuction procedure on one of his patients. Shortly before the commencement of the procedure, Dr Wong called Dr Zhu into the procedure room to assist in the procedure and to monitor the patient. A third person, Ms Fiona Hong, was also present, but she was not a registered medical practitioner.

6 No anaesthetist was in attendance. Instead, Dr Wong took it upon himself to manage the sedation of the patient, and for this purpose, he chose to use Propofol, which is an anaesthetic drug and a potent sedative that can *rapidly* depress the airway, impede respiration, and cause the recipient's blood pressure to fall. Because of its potency, the instruction sheet provided by its manufacturers clearly states that it should *only* be administered by physicians trained in anaesthesia or in the management of patients under intensive care. The rationale for this appears to be explained in the American Society of Anesthesiologists' 2002 "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" ("the ASA Guidelines") which are referred to in the agreed statements of facts that were prepared for the proceedings before the DT. The ASA Guidelines advise that practitioners administering Propofol should be qualified to rescue patients from any level of sedation including general anaesthesia, and medical practitioners who are not anaesthetists or intensivists would generally lack the training to perform such a task.

7 It is useful here to briefly explain some of the relevant medical terms for context. Sedation refers to a continuum of drug-induced states ranging from minimal to moderate to deep sedation and, at the end of the spectrum, general anaesthesia. General anaesthesia is a state of unconsciousness from which a patient cannot be aroused, even by painful stimulation. Patients in general anaesthesia may have impaired cardiovascular function and may often require assistance in maintaining their airways. Local anaesthesia, on the other hand, refers to the administration of an anaesthetic drug to a specific area of the patient's body for pain relief and does not involve sedation.

8 Dr Wong and Dr Zhu were neither anaesthetists nor intensivists, and, as they later admitted, did not have the necessary training or experience to administer Propofol safely or in accordance with the manufacturer's instruction

sheet. Indeed, from the clear warnings stated on the face of that instruction sheet, as well as from their prior involvement in surgeries in which Propofol had been administered by qualified anaesthetists, Dr Wong and Dr Zhu must be taken in fact to have known – and certainly ought to have known – about the potential dangers of administering Propofol. They would also have known that they lacked the qualifications and expertise to do so, given that they were not trained and qualified either as anaesthetists or as intensivists. In spite of this, they proceeded to administer Propofol to the patient at the start of the liposuction procedure.

9 To compound matters, they chose to administer Propofol in this case using a complex technique of continuous intravenous infusion by titration. This presented an even greater need for relevant expertise because when Propofol is administered in this way, its effects are prolonged according to the duration of the infusion. Both doctors accepted in the respective agreed statements of facts that the use of this titration technique to sedate a patient with Propofol is complex and "can only be provided by a well-trained, experienced and vigilant sedationist", which neither of them was.

10 As a result of their incompetence in the use of Propofol, the sedation was carried out in a manner that can only be described as appalling. In brief, as and when the patient was observed to exhibit any signs of responding to pain stimulation or any movement or discomfort, Dr Wong would instruct Dr Zhu to increase the dosage of Propofol. In the event, the dosage of Propofol that was administered was excessive, and it caused the patient to enter a state of deep sedation to the point of general anaesthesia. Given their lack of training, neither doctor was able to recognise the signs of this happening.

11 The patient's deep state of sedation owing to the overdose of Propofol had other repercussions on the liposuction procedure, which, as it transpired, was not performed competently. During the course of the liposuction procedure, Dr Wong inadvertently caused multiple puncture wounds to the patient's intestines. However, these went unnoticed because the patient was in a state of general anaesthesia and did not manifest any signs of pain.

12 The procedure lasted about three hours and ended at around 3.45pm. At about 3.50pm, Dr Zhu left the procedure room with Dr Wong's consent. Dr Wong proceeded to close the patient's surgical wounds and then left the room to use the toilet. While Dr Wong was in the toilet, the patient was not in the care of any medical practitioner or nurse for at least five minutes. Perhaps as a result of their incompetence in the use of Propofol, the doctors failed to realise that it was essential that the patient be closely monitored in light of the Propofol-related risks. According to the 2002 "Guidelines on Safe Sedation Practice for Investigation and Intervention Procedures" published by the Academy of Medicine, Singapore, which were in force at the time of the offence, a patient under sedation must have his circulation "monitored at frequent and clinically appropriate intervals" and his "[r]espiration must be monitored *continuously*" [emphasis added]. Instead, the doctors left the patient unattended in the immediate aftermath of the administration of Propofol while he was still sedated, with scant regard to patient care and safety. During this period, the patient developed an airway obstruction and suffered asphyxia leading to cardiac arrest. It was only at about 4.15pm that the patient was discovered to have collapsed, and an ambulance was then called to take him to the hospital.

13 When the patient arrived at the accident and emergency ("A&E") department of the hospital, he was found to be without a pulse. Dr Wong, who had accompanied the patient to the hospital, told the A&E doctors that the

patient had been given Pethidine, a pain medication, and local anaesthesia but no sedation. This was plainly a false statement as Dr Wong knew that the patient had been sedated with Propofol, and, as we have noted, this is a *potent* sedative. In our judgment, the false statement made by Dr Wong to the A&E doctors evidenced his knowledge that it had been improper for him to have administered Propofol. There is no other plausible explanation for his false statement; and certainly none has been advanced.

14 Despite resuscitation attempts by the A&E doctors, the patient passed away that day. He was aged 44.

Investigations and charges

15 On 4 January 2012, the coroner recorded the patient's death as a medical misadventure and that the patient had "died of the effects of asphyxia due to airway obstruction, secondary to intravenous Propofol administered." The coroner further noted that the patient had sustained multiple intestinal punctures during the liposuction procedure. These findings were referred to the SMC on 13 February 2012.

16 Upon further investigation by the Complaints Committee, Notices of Complaint were sent to Dr Wong and Dr Zhu on 13 November 2013. On 11 May 2015, both doctors were notified of the Complaints Committee's decision to convene a DT for an inquiry. On 9 February 2017, they were served formal Notices of Inquiry. By then, nearly five years had passed since the matter had been referred to the SMC.

17 Dr Wong's and Dr Zhu's inquiries took place before the DT on 22 September and 11 August 2017 respectively, and each doctor pleaded guilty to a charge which stated that they had "failed to exercise due care in the

management of [their] patient … in that [they] did not ensure adequate monitoring of the Patient during a medical procedure where [they] administered, or caused to be administered, Propofol to him, and as a result the Patient subsequently passed away." Dr Wong and Dr Zhu thus admitted that they were "guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap 174) in that [their] conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompanies registration as a medical practitioner."

18 In relation to both doctors' charges, the SMC proceeded under the second limb of professional misconduct laid down in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37], namely that the doctors' misconduct amounted to serious negligence that objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

The DT's decisions

19 The DT rendered its decisions in respect of both doctors on 13 December 2017. The DT concluded that Dr Wong bore a greater share of the responsibility than Dr Zhu who had been assisting him. Nonetheless, it found both doctors culpable for the serious consequences that had resulted from their actions. The DT also noted the importance of general and specific deterrence in determining the appropriate punishment. However, the DT was not persuaded that the maximum suspension term of three years sought by the SMC in respect of Dr Wong was warranted having regard to the facts of the case which, the DT considered, involved negligence rather than deliberate misconduct. The DT also gave credit to various mitigating factors raised by Dr Wong and Dr Zhu such as their early pleas of guilt, their unblemished professional records prior to 2009,

and the inordinate delay in the SMC's commencement and prosecution of the proceedings against them.

20 In all the circumstances, the DT ordered that Dr Wong be suspended from practice for 18 months, and Dr Zhu for six months. It further ordered that both doctors be censured, give written undertakings to the SMC that they would not engage in similar conduct in the future, and pay the costs of the DT proceedings.

21 OS 1 and OS 3 are Dr Wong's and the SMC's cross appeals against Dr Wong's sentence respectively, and OS 2 is the SMC's appeal against Dr Zhu's sentence. Dr Zhu did not appeal her sentence. The only aspect of the sentences that is in issue in each of the appeals is the suspension that was imposed on each of the doctors.

Sentencing principles

22 Before we turn to address the parties' arguments in these appeals, we think it would be helpful first to set out the relevant sentencing principles.

Objectives of sentencing

23 We begin with the main objectives of sentencing in this context. Disciplinary proceedings enable the profession to enforce its standards and to underscore to its members the values and ethos which undergird its work. In such proceedings, broader public interest considerations are paramount and will commonly be at the forefront when determining the appropriate sentence that should be imposed in each case. Vital public interest considerations include the need to uphold the standing and reputation of the profession, as well as to prevent an erosion of public confidence in the trustworthiness and competence

of its members. This is undoubtedly true for medical practitioners, in whom the public and, in particular, patients repose utmost trust and reliance in matters relating to personal health, including matters of life and death. As we observed in *Low Cze Hong* at [88], the hallowed status of the medical profession is "founded upon a bedrock of unequivocal trust and a presumption of unremitting professional competence", and failures by practitioners in the discharge of their duties must be visited with sanctions of appropriate gravity.

24 The primacy of these public interest considerations in the sentencing inquiry in disciplinary cases means that other considerations that might ordinarily be relevant to sentencing, such as the offender's personal mitigating circumstances and the principle of fairness to the offender, do not carry as much weight as they typically would in criminal cases; and, as we later explain, these considerations might even have to give way entirely if this is necessary in order to ensure that the interests of the public are sufficiently met: *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356 ("*Ang Peng Tiam*") at [118].

25 Second, the courts will also have regard to key sentencing principles of general application, such as the interests of general and specific deterrence. As we explained in *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201 ("*Kwan Kah Yee*") at [55]–[57], citing *Tan Kay Beng v Public Prosecutor* [2006] 4 SLR(R) 10 at [31], general deterrence, in particular, is a matter of considerable importance because it is "intended to create awareness in the public and more particularly among potential offenders that punishment will be certain and unrelenting for certain offences and offenders". This is a central and operative sentencing objective in most, if not all disciplinary cases. Specific deterrence, on the other hand, is directed at discouraging the *particular offender* from committing future offences, and the weight to be accorded to this

sentencing objective may be greater in cases involving recalcitrant offenders (see *Kwan Kah Yee* at [57]) as opposed to those with long, unblemished track records that are suggestive of a lack of propensity to reoffend: see *Ang Peng Tiam* at [105]–[107]. Yet another relevant sentencing objective is the need to punish the professional who has been guilty of misconduct.

26 Finally, considerations of fairness to the offender may, in appropriate cases, warrant the imposition of a lighter sentence. In cases such as *Ang Peng Tiam* where there had been inordinate delay in the SMC's prosecution of the disciplinary proceedings, we applied a sentencing discount in recognition of the prejudice that had been unfairly suffered by the offending doctor in the form of the mental anguish and anxiety that was caused by the pendency of the charge over a prolonged period of time. At the same time, we have previously emphasised that such considerations of fairness may be outweighed or even rendered substantially irrelevant by countervailing concerns in the public interest, especially in cases where the offence in question is particularly heinous: *Ang Peng Tiam* at [118]. Therefore, where important public interest considerations demand the imposition of a heavier penalty, the existence of prejudicial delay in the proceedings may have no mitigating effect at all in the sentencing of the offender.

Sentencing and the main categories of medical misconduct

27 In *Low Cze Hong* at [37] (see also *Ang Peng Tiam* at [31]), we identified at least two situations in which medical misconduct may be made out:

> (a) The first is where there has been an *intentional, deliberate departure* from the standards observed or approved by members of the medical profession who are of good repute and competency.

(b) The second is where there has been such *serious negligence* that it objectively portrays an *abuse of the privileges* which accompany registration as a medical practitioner.

For clarity of analysis, a distinction should be drawn between the two limbs when a charge is filed in individual cases so as to facilitate the comparison of like cases with like: see *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 ("*Lee Kim Kwong*") at [42]–[43].

28 Although cases involving intentional and deliberate wrongdoing may *commonly* attract heavier sentences relative to those which concern negligent misconduct, this will not invariably be the case. Depending on the facts of the case, negligent wrongdoing may be more serious and deserving of greater censure than intentional misconduct. In *Lee Kim Kwong* at [44], we cited a hypothetical example where a doctor's intentional departure from medically-approved standards may have been motivated by a genuine but mistaken concern for the patient's interests. Such a doctor may be regarded as less blameworthy than one who acted negligently but in blatant disregard of the patient's well-being. In such circumstances, it might well be the case that the negligent doctor ought to be visited with the more severe punishment particularly where his outright lack of concern for the patient's interests may have endangered the patient or caused her grave harm. The short point, we reiterate, is that each case must, in the final analysis, turn on its own facts.

The appropriate sentencing approach

29 In the context of cases where the misconduct of a medical practitioner has caused harm to the patient, sentencing should be approached in a systematic

manner. In our judgment, this can best be done in a series of steps as outlined below.

Step 1: Identify the level of harm and the level of culpability

30 The first step entails an evaluation of the seriousness of the offence, having regard to the two principal parameters of *harm* and *culpability*.

(a) *Harm* refers to the type and gravity of the harm or injury that was caused to the patient and indeed to society by the commission of the offence. It should also be noted that the more direct the connection between the specific type of harm that has been occasioned and the misconduct in question, the weightier a consideration this will be. The harm in question can take various forms, including bodily injury, emotional or psychological distress, even serious economic harm, increased predisposition to certain illnesses, loss of chance of recuperation or survival, and at the most severe end of the spectrum, death. Regard may also be had to the *potential* harm that could have resulted from dangerous acts of misconduct, even if it did not actually materialise on the given facts. In accordance with the position taken in criminal cases (see *Neo Ah Luan v Public Prosecutor* [2018] SGHC 188 ("*Neo Ah Luan*") at [67]), potential harm should only be taken into account if there was a *sufficient likelihood* of the harm arising; it would plainly not be appropriate to consider every remote possibility of harm for the purposes of sentencing.

(b) However, an unyielding focus on harm would yield an incomplete picture. With the best efforts of a doctor, a patient may nonetheless suffer serious injuries. And even where the harm is caused by a failure on the part of the doctor, different punitive and professional

> consequences will follow depending on the nature of that failure. This is why it is essential to also examine the *culpability* of the offender, by which we mean the degree of blameworthiness disclosed by the misconduct. This may be assessed by reference to the extent and manner of the offender's involvement in causing the harm, the extent to which the offender's conduct departed from standards reasonably expected of a medical practitioner, the offender's state of mind when committing the offence, and all of the circumstances surrounding the commission of the offence. Harm may be caused in a variety of ways, usually ranging in severity from negligent or careless acts, to grossly negligent acts, to knowing incompetence and recklessness. In some situations, it may even include intentional acts.

31 Together, these factors form the "harm-culpability matrix", according to which the sentencing court or tribunal may assess the seriousness of the offence and be guided to a suitable *starting point* in terms of the appropriate sentence. This too, is in line with the approach taken in criminal cases: see *Logachev Vladislav v Public Prosecutor* [2018] 4 SLR 609 ("*Logachev*") at [35]; *Neo Ah Luan* at [74(a)]; *Public Prosecutor v Koh Thiam Huat* [2017] 4 SLR 1099 at [41].

32 We think that a sentencing framework based on the harm-culpability matrix affords a useful means to calibrate the range of sentences to be imposed in cases where the misconduct of a medical professional has caused harm to the patient. The harm caused by the misconduct may be categorised as slight, moderate or severe; and the culpability of the errant doctor may similarly be categorised as low, medium or high. Because medical misconduct can accommodate a wide range of factual scenarios and types of harm, we do not think it would be desirable to be too prescriptive about what each of the different

levels of harm and culpability should entail. As the courts have noted in cases such as *Logachev* where a large number of harm and culpability-related factors were present (at [77]), the assessment of harm and culpability is ultimately a matter best left to the sentencing body in the exercise of its discretion. However, at [39]–[41] below, we set out a number of examples (by reference to past cases) which may be instructive in illustrating how the categorisation of harm and culpability according to this framework may be approached.

Step 2: Identify the applicable indicative sentencing range

33 The second step is to identify the applicable indicative sentencing range based on the level of harm and culpability identified in the first step of the analysis. Having regard to the range of punishments which may be imposed by the DT under s 53(2) of the Medical Registration Act and, in particular, the range of suspension terms which may be ordered under s 53(2)(*b*), we set out the following sentencing matrix as a guide to sentencing in cases where harm is caused to a patient by a doctor's misconduct in clinical care. For the avoidance of doubt and misunderstanding, this is set out as a guide only, in order to help sentencing tribunals weigh the relevant considerations in a systematic manner. This does not displace the duty upon each sentencing tribunal to consciously seek, determine and impose the sentence which is appropriate in all the circumstances, and therefore to depart from this matrix where it is appropriate to do so:

Harm / **Culpability**	**Slight**	**Moderate**	**Severe**
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

34 We make a few points in relation to the application of this sentencing matrix. First, cases involving slight harm and a low level of culpability may be punished by a fine, censure and/or any other order not amounting to suspension or striking off. Second, although it is envisioned that an order of suspension from practice may be warranted in many cases, we reiterate that this is not to say that suspension is the default or presumptive punishment; each case will turn on its own facts. In cases where an order of suspension is indeed warranted, this will commonly be accompanied by other punishments and orders including a fine, censure or the requirement of an undertaking to be furnished.

35 Third, it will also be seen that cases involving severe harm and a high level of culpability may call for the making of an order striking off the errant doctor from the register of medical professionals under s 53(2)(*a*) of the Medical Registration Act. In the discussion at [66]–[67] below, we set out a number of factors to which regard may be had when deciding whether to impose the

penalty of striking off. Further, we also explain at [72]–[73] below that in cases involving dishonesty, striking off should be seriously considered, and there may be no need to assess the levels of harm and culpability according to the framework presented above in such cases.

36 Fourth, we reiterate that this sentencing matrix is only applicable to cases where deficiencies in a doctor's clinical care causes harm to a patient, and not to other forms of medical misconduct such as overcharging, falsification of medical documents, inappropriate relations with a patient, or conduct which lies outside the ambit of a doctor's professional responsibilities to his patient but which leads to a conviction for a criminal offence implying a defect of character that renders the doctor unsuitable for registration as a medical practitioner. Although the considerations of harm and culpability may remain relevant, those cases are likely to involve considerations that are specific to the type of misconduct in question and which would not arise in cases relating to clinical care. Further, the types of harm caused by those forms of misconduct may be markedly different in nature to that which is caused by misconduct in the form of deficient clinical care, and it would therefore not be appropriate to assess those cases by reference to the same matrix. Instead, the appropriate sentencing ranges for those types of matters should be considered by reference to other cases involving similar circumstances.

37 Fifth, in line with our observation at [28] above that cases involving intentional and deliberate wrongdoing may *commonly but not invariably* attract heavier sentences relative to those which concern negligent misconduct, the former category of cases will *commonly but not invariably* be classified with a higher degree of culpability relative to cases falling within the latter category. As we have noted at [30(b)] above, the culpability of an errant doctor must be assessed by reference to all the circumstances surrounding the commission of

the offence, including not just whether the doctor intended to depart from the accepted standards of clinical care, but also the extent to which his conduct departed from those standards as well as his motivations and overall state of mind when committing the offence.

38 Finally, we are cognisant that the indicative sentencing ranges set out in the above matrix are likely to be heavier than sentences that have tended to be imposed in past cases. We take this opportunity to reiterate our view that the outcomes in many of the precedents cited by the parties in these proceedings were unduly lenient. We therefore do not regard many of those precedents as relevant when considering the appropriate sentence. We have previously signalled our intention to recalibrate sentencing benchmarks for cases of professional misconduct in the medical context, in respect of which, we have observed that the sentences cases have often been inexplicably lenient (*Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*") at [117]; *Kwan Kah Yee* at [34]; *Lee Kim Kwong* at [46]); hence, we think fair notice of this has been given to the medical community.

39 To elucidate the effect of our sentencing approach, we review some of the cases cited in the parties' submissions and examine how they might have been decided under the sentencing matrix we have set out here. The first is *In the Matter of Dr Amaldass Narayana Dass* [2014] SMCDC 2. In that case, Dr Amaldass did not adequately explain the risks of an open rhinoplasty procedure to his patient; failed to effectively sedate him or stop the procedure even though the patient indicated that he was not properly sedated and was in pain; left a gauze dressing in his nasal cavity without informing the patient; left remnants of a knotted thread in the patient's body after the procedure; and failed to remove an implant despite overwhelming evidence of infection. The Disciplinary Committee ("DC") ordered a six-month suspension and a $5,000

fine. We remarked in *Wong Him Choon* at [117] that the sentence in Dr Amaldass' case was "lenient" and "should have in fact been longer". According to the sentencing framework we have set out, we would peg the extent of harm in Dr Amaldass' case as "moderate" in the light of the actual injuries and pain and suffering caused to the patient as well as the greater harm that could potentially have resulted from his failure to remove the implant and other foreign objects which he had negligently left in the patient's body. We would categorise the level of culpability as "high" because of Dr Amaldass' sheer incompetence in his surgical and post-surgical care of the patient in so many respects and his failure to discharge his duty to keep the patient informed of important matters. In the event, the applicable indicative sentencing range for Dr Amaldass might have been suspension from practice for a term between two and three years.

40 A second example is *In the Matter of Dr Fong Wai* Yin [2016] SMCDT 7. Dr Fong's patient had presented with red eyes and high ocular pressure with blurred vision, severe headaches and vomiting on three visits over five days without improvement. Yet Dr Fong failed to provide a timely referral of the patient to an ophthalmologist or hospital for an urgent assessment. He misdiagnosed the patient as having acute viral conjunctivitis, a diagnosis which he likely would not have made had he conducted a visual acuity test on the patient as he should have done. He also failed to adequately document the patient's history. The patient later decided to seek a second opinion and was found to be suffering from bilateral acute angle closure glaucoma, and because of the delay in treatment, she developed tunnel vision and became unable to see more than a few feet in front of her. Dr Fong was suspended for three months. Without regard to any mitigating circumstances, the sentence imposed there seems to us to have been too lenient. We would consider that the extent of harm

was "moderate". Although the injury sustained by the patient was severe, we note that this may have been due to the patient's existing medical condition; the harm that was actually caused by Dr Fong seems to have been the patient's loss of chance to recuperate from that condition. We would consider that the level of culpability was "medium" as there was evidence that the patient's glaucoma condition was rare and difficult to diagnose. However, Dr Fong had fallen far below the accepted standards of clinical care by failing to conduct basic tests, provide a timely referral and maintain adequate notes. In the result, the applicable sentencing range could have been between one and two years' suspension.

41 Finally, the parties cited the case of *Lee Kim Kwong*, decided in 2014, which involved an obstetrics specialist who commenced a Caesarean section on his patient without first testing whether the anaesthetic administered earlier had taken full effect, and continued with the procedure even though his patient screamed in pain. In that case, we had observed at [39] that the doctor's haste was especially unacceptable when the circumstances were very far from those of an emergency, but nonetheless held at [49] that the nine months' suspension handed down by the DC was manifestly excessive and reduced the suspension to a term of five months (the $10,000 fine handed down by the DC was left undisturbed). The harm in that case was limited to the patient's pain and suffering during the operation and was, at least in relative terms, "slight", whereas the doctor's level of culpability would fall under the "medium" category in our judgment. Under our sentencing matrix, the facts surrounding the misconduct in *Lee Kim Kwong* would have placed it within the indicative range of three months' to one year's suspension, which both the DC's sentence and the reduced sentence on appeal would have fallen within. Determining the

appropriate sentence within that range would however require us to proceed to the remaining steps in the sentencing analysis, which we now turn to.

Step 3: Identify the appropriate starting point within the indicative sentencing range

42 Having identified the applicable indicative sentencing range, the third step is to identify the appropriate starting point *within* that range. Once again, regard is to be had to the level of harm caused by the misconduct and the errant doctor's level of culpability as well as how the case at hand compares to other cases featuring broadly similar circumstances. As we emphasised in *Logachev* at [79], this step does not involve double-counting of any factors; it is simply a matter of granulating the facts of case at hand in order to determine the appropriate starting point on the given facts.

Step 4: Make adjustments to the starting point to take into account offender-specific factors

43 The fourth step in the sentencing analysis involves consideration of the offender-specific sentencing factors which do not relate directly to the commission of the particular offence, but may nonetheless be sufficiently aggravating or mitigating so as to warrant an adjustment in the sentence to be imposed on the offender in each case. Potential mitigating factors include a timely plea of guilt in circumstances that indicate remorse on the offender's part, and having a long unblemished track record and good professional standing. In certain circumstances, an undue delay in the prosecution of the proceedings may be regarded as a mitigating factor. Aggravating factors might include prior instances of professional misconduct, especially where such antecedents bear similarities to the conduct underlying the charge in the case at hand, which may demonstrate the offender's recalcitrance and unwillingness to

adhere to the values and ethos of the profession or a troubling lack of insight into the errors of his ways.

44 Throughout the analysis, regard should be had to the sentencing objectives and public interest considerations, which we have outlined at [23]–[26] above and which remain of overarching importance. As we explained in the foregoing discussion, the public interest and the need for general deterrence will often be the central and operative considerations in the sentencing inquiry for disciplinary cases. For instance, a harsher sentence may be warranted as a starting point where there is a particular need to deter similar misconduct in the future and to restore public confidence in the integrity of the profession. Further, as we have noted at [24] and [26] above, because personal mitigating circumstances do not carry as much weight in disciplinary proceedings as they would in criminal cases, mitigating factors may be offset or even overridden entirely in certain cases, such as where general deterrence and the needs of the public call for the imposition of a stiff penalty as a sign of trenchant professional censure and disapproval.

Striking off

45 When a registered medical practitioner has been found guilty of professional misconduct under s 53(1)(*d*) of the Medical Registration Act or where any of the other grounds in s 53(1) apply, the DT is empowered to impose one or more of the many types of punishments listed in s 53(2). Most disciplinary cases of medical misconduct that have come before us have been visited with orders of suspension from practice under s 53(2)(*b*), for periods ranging between a minimum of three months and, occasionally, a maximum of three years; or a fine of up to $100,000 under s 53(2)(*e*). However, the most serious cases of misconduct would warrant the strongest signal of professional

sanction and disavowal: an order for removal of the errant doctor from the register of approved practitioners under s 53(2)(*a*).

46 Given the relative paucity of case law in which striking-off orders involving the medical profession were made, we set out some considerations to guide the sentencing analysis when striking off is contemplated as a possible sanction, with reference to the few local precedents where striking off was ordered as well as the positions taken in some other common law jurisdictions.

Local precedents

47 We are aware of four cases in the last decade where doctors were struck off the register for misconduct. All four were cases decided by a DC or DT and were not appealed to us. In the first case, *In the Matter of Dr AAN* [2009] SMCDC 2, Dr AAN was convicted of 20 charges of inappropriately prescribing hypnotic medication to various patients, who suffered from chronic insomnia and anxiety disorders, on an extended long-term basis. These prescriptions departed to an egregious degree from the existing guidelines, which cautioned that such medication should be used for short periods only. As a result, the patients who obtained the medication from Dr AAN became dependent on it. According to Dr AAN, he had taken it upon himself to prescribe the medication according to his own management plan for each patient, but the DC found that he was not qualified to do so and this should only have been done on the consultation of a qualified specialist, which Dr AAN clearly was not. Further, Dr AAN had not maintained adequate documentation of the patients' records and had failed to refer the patients to a specialist or specifically, a psychiatrist for further management of their underlying disorders, which the DC found that he ought to have done.

48 The DC also noted that Dr AAN had previously been struck off in 1993 after having been convicted of seven charges of over-prescription of another hypnotic drug and one charge of failing to keep proper records, but he had been restored to the register two years later. We digress to note that it was possible for restoration to occur so soon after the striking-off order because there were no temporal conditions required under the regime which existed at that time (see Medical Registration Act (Cap 175, 1985 Rev Ed)). The relevant legislation was later amended to require a minimum period of three years before a struck-off doctor could apply to the SMC for restoration: see Medical Registration Act 1997 (Act No 5 of 1997), s 46(2)(*a*); Medical Registration Act, s 56(2)(*a*). In contrast, an order from this court is required for a solicitor who has been struck off to be restored on the roll, although there is no statutory temporal limitation as to how soon after the imposition of the sanction an application for such restoration may be made. In Dr AAN's application for restoration, he had assured the SMC that he would treat and manage his patients better, but he nonetheless persisted in reoffending.

49 In the second case, *In the Matter of Dr Ho Thong Chew* [2014] SMCDT 12), a general practitioner, Dr Ho, pleaded guilty to 12 charges under s 53(1)(*b*) of the Medical Registration Act of having been convicted in Singapore of a criminal offence implying a defect in character which would make him unfit for his profession. Dr Ho had earlier been convicted under the Medicines Act (Cap 176, 1985 Rev Ed) of illegally selling large quantities of cough syrup containing codeine. In total, he sold 1,907 litres of the medication over the course of five months, knowing that it was meant for resale at a substantial profit. The DT further took into account as an aggravating factor the fact that Dr Ho had continued to blatantly disregard the law by persisting in dealing in the cough syrup even after his clinic had been raided by the Health Sciences Authority.

50 The third case, *In the Matter of Dr Ong Theng Kiat* [2015] SMCDT 2, also concerned a doctor who was charged after having been convicted of a criminal offence implying a defect in character, pursuant to s 53(1)(*b*). The case involved an obstetrician and gynaecologist, Dr Ong, who had pleaded guilty to two charges under s 376A(1)(*a*) of the Penal Code (Cap 224, 2008 Rev Ed) of sexual penetration of a minor under 16 years old. Dr Ong met the victim on a dating website, and despite knowing that she was only 14 years old, had unprotected sexual intercourse with her at a hotel and protected sexual intercourse in his car on a second occasion. After the first encounter, Dr Ong gave the victim two oral contraceptives from his clinic and advised her to consume them. The DT found that Dr Ong had lied to the victim about his age; and also about his true profession in order "[t]o cover up his fundamentally incompatible behavior as an obstetrician and gynaecologist". In the criminal proceedings, Dr Ong was convicted of a further charge under s 62(*a*) of the Medical Registration Act of knowingly making a fraudulent written declaration to the SMC in his application to renew his practising certificate, by stating that he had not been the subject of any investigations for improper conduct. At the material time, the police had already arrested Dr Ong and released him on bail pending investigations in respect of the aforementioned sexual offences. The DT held that the offence of sex with a minor was a grave offence which brought the profession into disrepute and that Dr Ong's attempt to hide his arrest from the SMC rendered him "fundamentally unsuited to continue as a registered medical practitioner".

51 The fourth case, *In the Matter of Dr Lee Siew Boon Winston* [2018] SMCDT 4 ("*Winston Lee*"), decided recently in May 2018, involved a general practitioner, Dr Lee who was convicted of two charges under s 354(1) of the Penal Code of using criminal force on his female patient with the intention of

outraging her modesty and one charge under s 62(*a*) of the Medical Registration Act of knowingly making a false declaration to the SMC. During Dr Lee's first consultation session with the patient, he slid his hand under her bra and touched her left breast, but the patient did not suspect any ill intent as she had complained of chest pain. Several months later, she went to see Dr Lee for a sore throat and expressed concern as to whether she would be able to continue exercising. Dr Lee asked her to stand on the weighing scale and lift her shirt. He did a pinch test on her stomach and commented that she was not fat. He then slid his hand under her bra and touched her left breast and nipple. The patient subsequently lodged a police report. Like Dr Ong in the previous case, while on bail pending investigations for the aforementioned sexual offences, Dr Lee knowingly made a fraudulent written declaration to the SMC in his application to renew his practising certificate, in which he stated that he had not been the subject of any investigations for improper conduct. He pleaded guilty to one charge under s 53(1)(*b*) of the Medical Registration Act of having been convicted of an offence implying a defect in character, and one charge under s 53(1)(*a*) of having been convicted of an offence involving fraud or dishonesty.

52 In the DT's grounds of decision, it considered the question of when an order striking off a doctor would be appropriate. To this end, it examined the cases of Dr AAN, Dr Ho and Dr Ong as well as the positions taken in the UK and Australia (which we will turn to shortly) from which it sought to extract general principles relating to striking off. The DT observed as follows at [53]:

> … Drawing the common threads together, the overarching test for when a removal from the Register is appropriate appears to be whether a practitioner has displayed serious misconduct such that he may be inferred to be lacking in the qualities of character which are necessary attributes of a person entrusted with the responsibilities of a medical practitioner, the lack of such qualities being fundamentally incompatible with continued registration. Additionally, in contemplating a removal from the Register, the need to protect the public and

> maintain the integrity of the medical profession are paramount considerations.

On the facts, the DT in *Winston Lee* found that Dr Lee's misconduct indeed implied a defect of character that rendered him fundamentally unsuited to continue as a registered medical practitioner and concluded that striking off was the only just and proportionate sanction to reflect his culpability and to uphold public confidence in the profession: at [83] and [87].

Positions in other common law jurisdictions

53 Given the limited case law in Singapore concerning the striking off of medical practitioners, we briefly consider the position in other common law jurisdictions on this question. In so doing, we bear in mind that there are appreciable differences between the statutory regimes of each jurisdiction on matters such as the standard of proof applicable in disciplinary proceedings. For instance, unlike in Singapore where disciplinary charges must be proved beyond a reasonable doubt, the standard of proof in England and Australia is the civil standard of proof on a balance of probabilities (see *Winston Lee* at [43] and [50], citing JK Mason and GT Laurie, *Law and Medical Ethics* (Oxford University Press, 8th Ed, 2011) at para 1.40 and *Medical Board of Australia v Myers* [2014] WASAT 137 at [8]); whereas a further requirement of "clear and cogent evidence" in addition to or as an enhancement of the usual civil standard has been recognised in several Canadian jurisdictions (see *Dr Q v College of Physicians and Surgeons of British Columbia* [2003] 1 SCR 226 at [11]; see also *Re Bernstein and College of Physicians and Surgeons of Ontario* (1977) 15 OR (2d) 447 where the court required proof that must be "clear and convincing and based upon cogent evidence"). Similarly, the specific rules concerning the length of suspension which may be ordered against an errant doctor (see *Kwan Kah Yee* at [40], citing ss 35D(2)(*b*) and 41A(1)(*a*) of the Medical Act 1983

(c 54) (UK) ("the UK Medical Act")) and the minimum duration before a struck-off doctor may apply for restoration (see *Winston Lee* at [44], citing s 41(2)(*a*) of the UK Medical Act) also differ across jurisdictions.

54 Notwithstanding these differences, we think it remains appropriate and useful for us to have regard to the positions taken in these jurisdictions when identifying the broad principles governing the imposition of a striking off order. This is especially true in view of the common sentencing objectives that underlie the approach adopted in all of these jurisdictions, namely, general and specific deterrence, the protection of the public, and the maintenance of public confidence in the profession: see *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879 ("*Bawa-Garba*") at [25]; *Re Dr Parajuli* [2010] NSWMT 3 at [32]; *College of Physicians and Surgeons of Ontario v Peirovy* [2018] ONCA 420 at [64].

55 In the UK, the General Medical Council ("GMC") has published the "Sanctions Guidance" which sets out the factors that tribunals should consider when imposing disciplinary sanctions on errant doctors, with reference also to the GMC's "Good Medical Practice" guide which provides explanatory guidance on what is expected of all doctors registered with the GMC. Although the Sanctions Guidance does not have statutory force, it is routinely considered by tribunals and courts in determining the appropriate sentence in each case: *Bawa-Garba* at [83]. The relevant paragraphs in the February 2018 edition of the Sanctions Guidance on the erasure of doctors from the medical register read as follows:

> **Erase the doctor's name from the medical register**
>
> 107 The tribunal may erase a doctor from the medical register in any case … where this is the only means of protecting the public.

> 108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.
>
> 109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).
>
> a A particularly serious departure from the principles set out in *Good medical practice* where the behaviour is fundamentally incompatible with being a doctor.
>
> b A deliberate or reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
>
> c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients …
>
> d Abuse of position/trust …
>
> e Violation of a patient's right/exploiting vulnerable people …
>
> f Offences of a sexual nature, including involvement in child sex abuse materials.
>
> g Offences involving violence.
>
> h Dishonesty, especially where persistent and/or covered up …
>
> i Putting their own interests before those of their patients …
>
> j Persistent lack of insight into the seriousness of their actions or the consequences.
>
> [internal citations omitted]

56 The Sanctions Guidance explains at para 92 that, in contrast, an order of suspension of practice "will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal

considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

57 Based on the Sanctions Guidance, the overarching inquiry as to whether erasure would be warranted involves asking whether the misconduct is "fundamentally incompatible with continued registration as a doctor" and whether erasure is necessary to protect the public or to maintain public confidence in the medical profession. Indeed, courts and tribunals in the UK commonly frame the issue in such terms when considering the possibility of erasure.

58 We refer in this connection to the decision of the High Court of England and Wales in *R (on the application of Balasubramaniam) v General Medical Council* [2008] EWHC 639 (Admin) ("*Balasubramaniam*"), the facts of which bear some similarities (albeit also considerable differences) to the present appeals. The doctor was an assistant anaesthetist who, on short notice, was assigned to anaesthetise a nine-year-old patient. He did not monitor the patient's blood loss during the operation and failed to notice or respond to any of the other warning signs such as her blood pressure and heart rate. As a result, the patient lost at least 800ml of blood, which amounted to 40% of the blood that a child of her age would have had in her body. According to the doctor, he did not have experience in the anaesthetic monitoring of young children, an operation which would usually have been done by a consultant anaesthetist. Despite this, he did not seek assistance or do anything about the patient's blood loss until the consultant anaesthetist arrived and directed remedial measures. The court remarked at [15]:

> … The [Sanctions] Guidance suggests that the sanction of erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a doctor and involves any of the following non-exhaustive list. First, serious departure

> from the relevant professional standards as set out in Good Medical Practice. I here interpolate that this must mean *particularly* serious departure, since a serious departure is what is required before a sanction of any sort can be imposed in the first place. Secondly, one of the indicators for erasure is "persistent lack of insight into seriousness of actions or consequences"…

59 Relying on the findings of the Fitness to Practice Panel that there had indeed been a particularly serious departure from relevant professional standards (at [20]) and that the errant doctor showed a persistent lack of insight in his responses during cross-examination as to his willingness to recognise the deficiencies in his practice and undergo retraining (at [20]–[22]), the court upheld the Panel's sanction of erasure.

60 The statements of general principle set out in the Sanctions Guidance are broadly in line with those articulated by the Western Australia State Administrative Tribunal in *Medical Board of Australia v Duck* [2017] WASAT 28 ("*Duck*"), cited by the Victorian Civil and Administrative Tribunal in *Medical Board of Australia v Alkazali (Review and Regulation)* [2017] VCAT 286 at [74] and *Winston Lee* at [51]:

> **Cancellation of registration**
>
> The jurisdiction of the Tribunal to cancel a practitioner's registration is exercised not for the purpose of punishing the practitioner concerned, but for the protection of the public and the reputation and standards of the medical profession.
>
> Where an order for cancellation of a practitioner's registration is contemplated, *the ultimate question is whether the material demonstrates that the practitioner is not a fit and proper person to remain a practitioner.*
>
> A practitioner is not a fit and proper person to be a registered practitioner and should be removed from the register *where the conduct is so serious that the practitioner is permanently or indefinitely unfit to practise.*
>
> …
>
> **Suspension**

> …
>
> The proper use of suspension is in cases where the practitioner has fallen below the high standards to be expected of such a practitioner, but not in such a way as to indicate that the practitioner lacks the qualities of character which are the necessary attributes of a person entrusted with the responsibilities of a practitioner. That is, suspension is suitable where the Tribunal is satisfied that, upon completion of the period of suspension, the practitioner will be fit to resume practice.
>
> [emphasis added; citations in original omitted]

61 *Duck* involved a general practitioner who had, among other things, engaged in sexualised behaviour with a patient, overprescribed her with tranquilising medication over an extended period of time when he ought to have known that she was abusing or selling it, and practised beyond his competence by undertaking a detoxification programme in her hotel room. Having regard to the need to protect the public and to maintain public confidence in the medical profession, the tribunal cancelled the doctor's registration.

62 But what is most relevant for our present purposes is the threshold standard for the cancellation of a doctor's registration which was set out by the tribunal in *Duck*, which is to the effect that the misconduct must be so serious that it leads to the conclusion that the doctor is permanently or indefinitely unfit to practise or remain a doctor. This broadly accords with the position in the UK Sanctions Guidance that the misconduct must be "fundamentally incompatible with continued registration as a doctor" if erasure is to be ordered.

63 Beyond these overarching propositions, foreign courts and tribunals have also relied on more specific factors to assess whether a striking-off order is appropriate in a particular case. As set out in the Sanctions Guidance at para 109, these factors include: where a doctor has abused his position and privileges; where serious harm has been done to others either deliberately or

through incompetence; where there has been a particularly serious departure from the accepted standards of a doctor; where the misconduct in question evinces a serious defect of character such as dishonesty; and where the doctor showed a persistent lack of insight into the seriousness or consequences of his misconduct: see also *Balasubramaniam* at [20]–[22].

64 To further illustrate the application of these factors, we refer to the decision of the Ontario Superior Court of Justice in *Hill v College of Physicians and Surgeons of Ontario* [2018] ONSC 5833 ("*Hill*"), where a family physician was investigated following a complaint by a patient that he had failed to diagnose the patient's colon cancer. During the investigations, it was discovered that the physician had been falsifying his patients' charts by indiscriminately copying and pasting other patients' histories into those charts in order to reduce his workload. The court agreed with the disciplinary committee's findings that the physician posed a serious risk to the public due to his "incompetence, his inability to self-reflect, his ability to deceive, and his ongoing denial and lack of insight" at [31] and [47], and affirmed the disciplinary committee's decision to revoke his certificate of registration. It is clear that the factors that were taken into account in *Hill* would also have been relevant to the broader inquiry as to whether the physician's misconduct was "fundamentally incompatible with continued registration as a doctor" or so serious that the physician was permanently unfit to practise, in line with the positions adopted in the UK and Australia.

General principles

65 From the foregoing cases and authorities, we identify a number of common threads and distil a few principles and factors that would be relevant in guiding a sentencing court or tribunal as to whether to impose the penalty of

striking off. We emphasise, however, that the inquiry is a highly fact-sensitive one, and we go no further than to identify principles of general application, so as not to be unduly prescriptive.

66 In our judgment, when deciding whether or not to strike a doctor off the register of medical practitioners under s 53(2)(*a*), the ultimate question is whether the misconduct was so serious that it renders the doctor unfit to remain as a member of the medical profession. We note that this is in line with the approach we have taken in relation to the striking off of solicitors: see *Law Society of Singapore v Wong Sin Yee* [2018] SGHC 196 at [24]; *Law Society of Singapore v Ismail bin Atan* [2017] 5 SLR 746 ("*Ismail*") at [22]. If a doctor's conduct is so fundamentally at odds with the values of the medical profession, then the only logical consequence that follows is that he must be struck off.

67 We set out a number of factors that may be relevant to this broader inquiry:

(a) Striking off should be considered when the misconduct in question involves a flagrant abuse of the privileges accompanying registration as a medical practitioner. This was certainly the case in relation to Dr AAN, Dr Ho as well as the doctor in *Duck*. These cases involved doctors who had access to prescription drugs by virtue of being doctors, and grossly violated the trust that had been placed in them by their profession and by society.

(b) Striking off should also be considered where the practitioner's misconduct has caused grave harm. Such harm was evident in relation to the individual patients in Dr AAN's case as they developed a dependency on the hypnotic drugs he had prescribed, as well as the child patient in *Balasubramaniam* who suffered severe blood loss. Although

there was no single identifiable victim or patient in Dr Ho's case, serious harm was caused to society as a whole as a result of his actions which undoubtedly would have facilitated the black market trade and abuse of addictive controlled substances by numerous unidentified victims. In *Hill*, it was evident that the appalling way in which the doctor maintained his patients' charts created a real risk of enormous *potential harm* to his patients. It is safe to say that these doctors endangered their patients, abdicated their responsibility and calling as doctors and posed a risk to the public. Society has no interest or benefit at all in permitting such persons to continue to practise medicine.

(c) Culpability will be a critical and relevant consideration in this analysis. Dr AAN and Dr Ho, in *deliberately and improperly* prescribing and selling controlled medicines over *extended periods of time*, had acted in callous disregard of their professional duties as well as the health of their patients or the general public. The same applies to the doctor in *Hill* who abdicated his basic duties as a doctor by falsifying his patients' charts for no reason other than his own sloth. The harshest of sanctions was therefore warranted to punish the errant doctors severely and to ensure that their misconduct would not bring the profession into disrepute.

(d) Where a doctor's misconduct evinces a serious defect of character, striking off is likely to be appropriate. This might arise from conduct underlying a predicate criminal conviction which is harmful to the repute of the profession or incompatible with the offender remaining a member of it, and the disciplinary charge is brought under s 53(1)(*b*) of the Medical Registration Act, as in the cases of Dr Ong and Dr Lee where sexual offences were committed. This might also arise

independent of any criminal proceedings but where the character defect relates directly to the doctor's professional duties: see *Duck* and *Hill*. The position here is similar to that which we take in respect of errant solicitors. In *Ismail* at [21], we noted that "even in cases that do not involve dishonesty, where a solicitor conducts himself in a way that falls below the required standards of integrity, probity and trustworthiness, and brings grave dishonour to the profession, he will be liable to be struck off" [emphasis omitted].

(e) Striking off should be considered when the facts of the case disclose an element of dishonesty. In Dr AAN's and Dr Ho's cases, deception was inherent in the maintenance of inaccurate patient records and other clinical documents in order to facilitate the improper prescription and sale of the hypnotic drugs and cough syrup respectively. Dr Ong, on the other hand, had lied to the victim to encourage her to having sexual intercourse with him, and both Dr Ong and Dr Lee had lied to the SMC when they falsely stated in their written forms that there were no investigations against them in order to get their practising certificate renewed. Dishonesty on the part of a professional will generally be viewed with severity. In the following section, we will set out in greater detail our views on the relevance of dishonesty in the disciplinary context.

(f) Finally, where any of the above factors exist, a further consideration which might suggest that the punishment of striking off is especially warranted, is where the errant doctor has shown a persistent lack of insight into the seriousness and consequences of his misconduct. As noted by the courts in *Balasubramaniam* and *Hill* (see [59] and [64] above), this factor was present in both of those cases. It was also present

> in the case of Dr AAN, who was struck off for similar offences but proceeded to reoffend after he had been restored to the register. We emphasise that this will generally be a further or *additional* factor, in that there must be sufficiently serious misconduct before a doctor's persistent lack of insight may contribute to a finding that striking off would be appropriate. In such cases, the lack of insight might suggest an impediment to reform or rehabilitation which warrants the sanction of striking off.

The relevance of dishonesty

68 The rule on dishonesty which applies to lawyers is clear and well-settled. In *Law Society of Singapore v Chia Choon Yang* [2018] SGHC 174 ("*Chia Choon Yang*") at [39], we stated that "misconduct involving dishonesty will almost invariably warrant an order for striking off where the dishonesty reveals a character defect rendering the errant solicitor unsuitable for the profession, or undermines the administration of justice". The rationale for this was explained in *Law Society of Singapore v Ravi s/o Madasamy* [2016] 5 SLR 1141 at [48] where we observed that "[d]ishonesty attacks the very core of trustworthiness and integrity of a solicitor, and in a broader sense, the integrity of the profession and the legitimacy of the administration of justice."

69 However, a different approach appears to have applied in relation to the medical profession. In *Law Society of Singapore v Ong Cheong Wei* [2018] 3 SLR 937 at [10]–[12], a case where we struck off a solicitor who had committed wilful tax evasion, we doubted the correctness of past cases where doctors and engineers who had been found guilty of similar offences did not have their registrations revoked, observing that "the leniency which is sometimes shown to errant members of other professions seems inconsistent with the strict

approach we take to dishonest lawyers." The DT in *Winston Lee* also took notice of this inconsistency, and although it was "seriously concerned with Dr Lee's attempt to conceal the investigations against him" by making a false declaration to the SMC in his application to renew his practising certificate, the DT noted that the relevant precedents for that charge suggested that the appropriate punishment would be a fine of around $10,000, a position which all counsel accepted in submissions: at [81]–[82].

70 But is this disparity well-founded in principle? The answer, we think, is that it is not, and the reason for this lies in the concept of a *profession*. One of the key characteristics identified by Francis Bennion in his definition of a profession is the tradition of service and furtherance of the public good: FAR Bennion, *Professional Ethics: The Consultant Professions and Their Code* (Charles Knight, 1969), pp 14–15. In *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 ("*Susan Lim*") at [39], we observed that "the idea that the practice of medicine is, above all, a calling of the higher order is a historical cornerstone of the medical profession." Indeed, this idea can be traced all the way back to ancient Greece, the birthplace of one of the earliest expressions of medical ethics: the Hippocratic Oath. The SMC Physician's Pledge, which is taken by every doctor upon admittance as a registered medical practitioner, binds the new doctor to various beneficent commitments such as to "dedicate [one's] life to the service of humanity", "practise [one's] profession with conscience and dignity", and "uphold the honour and noble traditions of the medical profession": Medical Registration Regulations 2010 (S 733/2010), Second Schedule.

71 It is clear that the time-honoured values of honour, integrity and honesty are not only important for the legal profession (see *Law Society of Singapore v Rasif David* [2008] 2 SLR(R) 955 at [52]), but also integral to the ethos of the

medical profession. As we have said at [23] above, doctors are routinely entrusted with matters of grave importance including those involving life and death, and the trust and confidence reposed by a patient in his doctor is certainly no less than that which applies in a solicitor-client relationship. In *Chia Choon Yang* at [42], we observed that the commitment of lawyers to the values of truth, honesty and ethics is shared with members of the medical profession and that there ought to be greater consistency in the way that each profession responds to grave breaches of such values.

72 Therefore, as a general rule, misconduct involving dishonesty should almost invariably warrant an order for striking off where the dishonesty reveals a character defect rendering the errant doctor unsuitable for the profession: see *Chia Choon Yang* at [39]. This would typically be the case where dishonesty is integral to the commission of a criminal offence of which the doctor has been convicted, or where the dishonesty violates the relationship of trust and confidence between doctor and patient. In our judgment, exceptional circumstances would have to be shown to avoid its imposition in such circumstances.

73 Where dishonesty is shown, but the circumstances are not such as we have set out in the preceding paragraph, the sentencing court or tribunal should examine all the circumstances of the case to determine whether striking off is nonetheless warranted. Taking reference from the approach we laid down in *Chia Choon Yang* at [40], the following non-exhaustive list of factors should be considered:

(a) the real nature of the wrong and the interest that has been implicated;

(b) the extent and nature of the deception;

> (c) the motivations and reasons behind the dishonesty and whether it indicates a fundamental lack of integrity on the one hand or a case of misjudgment on the other;
>
> (d) whether the errant [doctor] benefited from the dishonesty; and
>
> (e) whether the dishonesty caused actual harm or had the potential to cause harm that the errant [doctor] ought to have or in fact recognised.

74 The application of the foregoing principles to the medical profession will bring the position with respect to professional discipline of doctors more closely in line with that for lawyers, and also coheres with the approach taken in the UK. In *Gupta v The Professional Conduct Committee of the General Medical Council* [2002] 1 WLR 1691 ("*Gupta*") at [21], the errant doctor had allowed her husband to hold consultations with patients at her surgery premises even though she knew that his name had been erased from the register because he had been found guilty of serious professional misconduct. Referring to the judgment of Sir Thomas Bingham MR (as he then was) in *Bolton v Law Society* [1994] 1 WLR 512, 517H–519E which laid down the dishonesty rule for lawyers in England, Lord Rodger (at [20]–[21]) found it appropriate to apply the same approach in affirming the erasure of the doctor in *Gupta* and echoed Sir Bingham MR's remark that:

> The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price.

We think that the broad alignment of positions between the medical and legal professions is appropriate and overdue, given that honesty is just as essential to the discharge of a doctor's duties as it is for lawyers. This also gives greater effect to the overarching sentencing objectives of general deterrence and the need to safeguard public confidence in the medical profession.

Summary of sentencing principles

75 In our judgment, the foregoing analysis may be summarised as follows:

(a) In disciplinary cases involving medical misconduct, the key sentencing objectives are to uphold confidence in the medical profession; to protect the public who are dependent on doctors for medical care; to deter the errant doctor and others who might be similarly disposed from committing similar offences; and to punish the errant doctor for his misconduct. The interest of the public is paramount and will prevail over other considerations such as fairness to the errant doctor.

(b) A distinction should be maintained between cases involving intentional, deliberate acts (which fall within the first limb of *Low Cze Hong*) and those involving serious negligence (which fall within the second limb), so that similar cases may be compared. However, each case will turn on its own facts, and cases involving intentional wrongdoing are not invariably more serious or deserving of heavier punishment than those which concern negligent misconduct.

(c) Where a doctor's misconduct results in harm to a patient, the correct sentencing approach is for the court or tribunal to first evaluate the seriousness of the offence according to the two principal parameters of harm and culpability. Having assessed the levels of harm and culpability based on the facts of the case, it should determine the applicable indicative sentencing range with reference to the matrix set out at [33] above, and then identify the appropriate starting point within that range. Finally, it should consider the aggravating or mitigating factors which do not relate directly to the commission of the offence,

and adjust the sentence on this basis. Throughout this analysis, the relevant sentencing objectives and considerations referred to at sub-paragraph (a) above should be kept in mind. In particular, it should be noted that personal mitigating circumstances carry less weight in disciplinary proceedings and may be overridden by the public interest, particularly where the misconduct is of a sufficiently serious nature.

(d) The court or tribunal should not hesitate to strike off an errant doctor where the misconduct was so serious that it renders the doctor unfit to remain as a member of the profession.

(e) Further, where dishonesty reveals a character defect rendering the errant doctor unsuitable for the profession, such as where the dishonesty is integral to the commission of a criminal offence of which the doctor has been convicted, or where it violates the relationship of trust and confidence between doctor and patient, striking off will be the presumptive penalty, absent exceptional circumstances.

(f) In other cases of dishonesty, all the relevant facts and circumstances should be carefully considered in order to determine whether striking off is nonetheless warranted.

Dr Wong (OS 1 and OS 3)

76 With these principles in mind, we turn to consider the appeals against Dr Wong's and Dr Zhu's sentences. We begin with Dr Wong who was the doctor in charge of the patient's care.

The parties' cases

77 Dr Wong's position is that the sentence of 18 months' suspension meted out by the DT was manifestly excessive. He relies on our decision in *Lee Kim Kwong* to contend that in cases involving serious harm to patients and a negligent omission on the part of the medical practitioner, a three-month suspension is the suggested starting point. Having regard to the gravity of his misconduct, Dr Wong submits that the appropriate sentence for him would have been six months' suspension, but that this should then be halved to three months on the basis of the SMC's inordinate delay in prosecuting the matter.

78 Dr Wong further contends that the DT erred in several specific respects. First, he submits that the DT improperly took into account the ASA Guidelines which have only been adopted by one restructured hospital in Singapore and thus do not serve as a standard of general application to local doctors. He also contends that the DT failed to take into account the fact that there is a very low chance of him reoffending given that he is no longer allowed to perform liposuction procedures or to administer Propofol. He also maintains that the DT did not give a sufficient discount for the inordinate delay in the prosecution of the case against him.

79 On the other hand, the SMC takes the position that the 18-month suspension term ordered by the DT is manifestly inadequate. It submits that the DT failed to place sufficient weight on the severity of the consequences suffered by the patient, the principle of general deterrence, and the significant aggravating factors in that Dr Wong was practising outside the scope of his competency and dishonestly attempted to cover up the fact that he had administered Propofol to the patient. The SMC further contends that the DT placed undue and excessive weight on mitigating factors such as Dr Wong's

early plea of guilt and the settlement of civil liability stemming from the patient's death.

80 In its written submissions, the SMC sought an increase in Dr Wong's suspension term to the statutory maximum of three years. However, when asked at the hearing as to the appropriateness of striking Dr Wong off the register of medical practitioners, Mr Philip Fong, who appeared for the SMC, responded that such an order would indeed be warranted in the circumstances of this case.

Our decision

81 As we stated at the outset, the facts presented in Dr Wong's case make it one of the most egregious cases of medical misconduct that have come before us. We reach this conclusion having regard to the harm-culpability matrix we have set out at [33] above.

Harm

82 It is clear that this case involved the most severe harm imaginable. We emphasise that the severity of the consequences here went beyond those of any of the past cases of medical misconduct that were cited to us by counsel for Dr Wong, including other cases which may have involved the death of a patient. For instance, in *Ang Peng Tiam*, a patient passed away after her oncologist had falsely represented the chance that her disease would respond to his prescribed therapy and failed to offer her an alternative option of surgery. In *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745 ("*Eric Gan*"), because of the surgeon's negligent mismanagement of the patient's post-operative treatment, a known surgical complication was not discovered and this led to the patient's death.

83 Dr Wong's submissions approach the question of harm solely as a question of *injury*. But that is not correct. The focus should first be on what harm was *directly caused* by the doctor's misconduct. In our judgment, neither *Ang Peng Tiam* nor *Eric Gan* even approaches the gravity of the harm that was caused by Dr Wong. In *Ang Peng Tiam*, the misconduct of the oncologist did not *cause* the patient's death. The patient was already suffering from life-threatening cancer. What the oncologist did improperly was to present an unduly optimistic prognosis to the patient without having tested for a particular mutation, when his prognosis would only have been justified had the patient tested positive for that mutation. And in *Eric Gan*, the patient succumbed to a known complication of surgery. The surgeon did not cause the complication by his misconduct. Instead, the misconduct arose from the surgeon's failure to discover that the complication had set in.

84 In contrast, the present case did not involve a mere omission to provide lifesaving treatment, a loss of chance of survival, or any pre-existing risk inherent in the nature of the patient's medical condition or in the medical procedure undergone by the patient. In such situations, due regard should be had to the occupational risks faced on a daily basis by medical practitioners. But none of these hazards was an inherent feature of this case. In truth, it simply would not even have been contemplated by the patient, who had consulted Dr Wong for *an elective aesthetic procedure*, that he would not survive the operation. It was the doctors' actions here which were the sole and direct cause of the patient's death, and we regard this as an extremely serious aggravating factor to be taken into account in sentencing.

Culpability

85 Turning to culpability, we identify a number of factual points regarding Dr Wong's conduct during and after the liposuction procedure that bear emphasis.

86 First, Dr Wong made the decision to administer Propofol, a potent and dangerous sedative, despite the fact that neither he nor Dr Zhu had the necessary training and experience to do so. He ignored the explicit warnings on the manufacturer's instruction sheet which indicated that the drug was not to be administered except by someone trained as an anaesthetist or intensivist. No plausible explanation was advanced as to why Dr Wong thought that he could administer Propofol himself on this occasion, when sedation had been handled by qualified anaesthetists in previous procedures of this sort that he had been involved in. In our judgment, the inescapable inference is that Dr Wong embarked on a procedure that he knew he was not qualified to undertake, even if, subjectively, he might have believed he could do it. Such a subjective belief would not detract from his conscious decision to do something that he knew he was not qualified to do.

87 We emphasise that we have relied mainly on the prohibitions stated on the manufacturer's instruction sheet in arriving at the finding that Dr Wong had known that he was not qualified to administer Propofol. We considered the ASA Guidelines only as background to aid our understanding of why the Propofol should only be administered by anaesthetists and intensivists: see [6] above. We make this observation because Dr Wong has made the argument that the DT erred in relying on the standards set out within the ASA Guidelines in finding that he had improperly administered Propofol. He contends that the DT should not have done so because the ASA Guidelines had only been adopted by one

local restructured hospital at the time of the offence and so could not be regarded as representing the prevailing standards. We reject this argument. In the first place, that is premised on a mistaken reading of the DT's grounds of decision in respect of Dr Wong's case. Dr Wong's submissions misconstrue the DT's use of the phrase, "Standards of the Duty of Care and Professional Conduct" (at [14]), as referring to the ASA Guidelines, when the DT was instead referring generally to the minimum standards that are expected of a doctor. Indeed, in its grounds of decision in respect of Dr Zhu's case, the DT expressly recognised at [13] that it would be inappropriate to apply the ASA Guidelines because it was not "a controlling Singapore policy of general application to medical professionals … in 2009."

88 Second, Dr Wong and Dr Zhu administered Propofol using a complex technique of continuous intravenous infusion by titration which they were even less qualified and trained to perform. As both doctors accepted in their agreed statements of facts, this could only be performed "by a well-trained, experienced and vigilant sedationist": see [9] above. On no basis could it be contended that either doctor was trained or experienced in this way. Because of this, the patient was administered a dose of Propofol under Dr Wong's directions which both doctors later accepted had been "excessive in all the circumstances".

89 Third, the liposuction procedure itself was performed unsatisfactorily. Dr Wong caused multiple puncture wounds to the patient's intestines which went unnoticed because of the patient's state of deep sedation and inability to respond to pain. As a result, Dr Wong was not even aware that he had inflicted the serious puncture wounds on the patient. These additional injuries caused by Dr Wong constitute yet another aggravating factor that we take into consideration.

90 Fourth, the patient was left unattended for at least five minutes shortly after the conclusion of the liposuction procedure, when his respiration should have been monitored "continuously" until he had come out of sedation: see [12] above. The doctors' failure to render post-procedure treatment was directly causative of the patient's death, and Dr Wong himself accepted that "medical attention could have been provided in time to prevent the patient from asphyxiating to death" if he had adequately monitored the patient following the liposuction.

91 Finally, at the hospital, Dr Wong informed the A&E doctors that he had not sedated the patient and had only administered local anaesthesia and pain medication. DT described Dr Wong as having been "economical with the truth". In fact, his statement was patently false. The deceit was not included as one of the particulars of the charges brought against Dr Wong. We therefore do not rely on it as affording an independent basis for our decision. However, Dr Wong's attempt to cover up his actions by lying to the A&E doctors, in our judgment, evidences the fact that he had *known* all along that it was improper for him to administer Propofol. This was why he had tried to conceal this fact to the A&E doctors. This was relevant not only to our finding in relation to Dr Wong's state of mind when he undertook this procedure, but also to the fact that despite the extreme danger the patient was in, Dr Wong preferred his own interest and lied in a misguided attempt to protect himself, rather than attempt to equip the A&E doctors with the most complete information to enable them to try to save the patient.

92 Having considered Dr Wong's case, we find it difficult to conceive of a worse case of medical misconduct. From recklessly deciding to embark on a risky sedation procedure despite being untrained; to administering the sedative improperly by giving an excessive dosage; to wounding the patient by

performing the liposuction improperly in circumstances where because of the incompetent and excessive dosage of the sedation, he had no way of even knowing he was inflicting unintended and potentially serious injuries on the patient; to leaving the patient unattended post-procedure as a result of which the patient asphyxiated and eventually died; and finally, to lying to the A&E doctors, Dr Wong's treatment of the patient was grossly unsatisfactory and strikingly deficient in every respect. We agree with the SMC's submission that the numerous aggravating factors present here make Dr Wong's misconduct among the worst of its kind and which must be punished with a sanction of sufficient severity.

93 The DT held that Dr Wong's case was distinguishable from *Susan Lim* and *Kwan Kah Yee* where the maximum term of three years' suspension was meted out to the errant doctors. This was partly on the basis that the charges in these two precedents were brought under the first limb of medical misconduct identified in *Low Cze Hong* (see [27] above) involving *intentional* departures from standards observed or approved by members of the profession of good repute and competency. In contrast, Dr Wong's charge was brought under the second limb of *Low Cze Hong*, which applies when there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner. However, this failed to recognise the importance of assessing each case according to its particular facts.

94 We highlight a few points in response to the DT's findings and the parties' submissions in this regard:

(a) First, even though the SMC proceeded under the second *Low Cze Hong* limb of serious negligence, we think on the facts here, Dr Wong's case could comfortably have been brought under the first limb involving

deliberate departures from accepted standards. As we have noted at [8] and [86] above, Dr Wong had intentionally administered Propofol to the patient despite knowing that he was not qualified to do so.

(b) Second, counsel for Dr Wong, Mr Christopher Chong, submitted at the hearing before us that we should take a generous view in the circumstances because there was never any intention on Dr Wong's part to harm the patient. This argument does not assist Dr Wong in the slightest, because as we pointed out to Mr Chong, if Dr Wong had intended the death of the patient, this would have been a case of homicide instead of medical misconduct.

(c) Third, as we made clear at [28] above, and as we reiterate here, cases under the first limb of *Low Cze Hong* do not invariably attract heavier sanctions than cases under the second limb. Serious negligence in certain circumstances may demonstrate a graver lack of concern for the patient than a deliberate albeit well-intentioned departure from medically-approved standards, and would thus warrant greater punishment. Dr Wong's case indeed falls within such a category. In these circumstances, we would not hesitate in imposing the harshest sanctions simply because the charge was brought under the second limb rather than the first.

(d) Fourth, the facts underlying *Susan Lim* and *Kwan Kah Yee* were quite different in that those cases involved overcharging and improper certification of death respectively. While those were cases of serious misconduct, Dr Wong's misconduct was considerably more egregious, having regard to the fact that he *caused* the patient's death by his actions

which could only be regarded as being of a very high degree of culpability.

The applicable indicative sentencing range and appropriate starting point within that range

95 Having found that Dr Wong's misconduct was of a high degree of culpability and resulted in severe harm, the applicable indicative sentencing range is the maximum term of three years' suspension or an order of striking off (as shown in the matrix at [33] above).

96 We note that this sentencing range significantly diverges from the sentences imposed in the precedents cited by Dr Wong which involved serious negligence; in those cases, the sanctions ordered were generally suspensions for periods of between three and six months. We have explained our view at [38]–[40] above that many of these precedents reflect unduly lenient sentences and that they should no longer be relied upon for guidance in determining the appropriate sentence. Having said that, we are conscious that Dr Wong's and Dr Zhu's misconduct occurred in 2009 prior to our decisions in *Wong Him Choon*, *Kwan Kah Yee* and *Lee Kim Kwong* where we signalled our intention to recalibrate sentences for medical misconduct cases. But in light of the clear factual distinctions between the present case and the precedents cited by Dr Wong, it is not necessary for us to rely on overruling those precedents when determining the appropriate sentences in the case at hand. None of these precedents come close to the level of egregiousness in the present case.

97 Only one case, *Eric Gan* (see [82] above), involved the death of a patient, and even so, we reiterate that the death in that case had not been solely and directly caused by the doctor's misconduct: see [82]–[83] above. Dr Wong's submissions regarding these precedents also fail to properly address the

numerous facts that relate to his high degree of culpability, including his knowing administration of a dangerous sedative that he was not qualified to administer, his failure to adequately monitor the patient, and his lie to the A&E doctors. In this regard, his reliance on past cases involving doctors who had negligently failed to make prompt referrals or run diagnostic tests (for example, *Chia Foong Lin v Singapore Medical Council* [2017] 5 SLR 334 and the case of Dr L E (cited in *Lee Kim Kwong* at [35])) is simply misplaced.

98 In our judgment, because of the utmost severity of the harm caused by Dr Wong and the very high degree of his culpability, the misconduct in this case was so serious that it clearly rendered him unfit to continue to practise as a doctor. We therefore think the appropriate "starting point" on the basis of the offence-specific factors in this case is an order of striking off; even the maximum term of suspension would not suffice. We now turn to the final step in the analysis, which is to consider the effect of Dr Wong's personal mitigating circumstances, if any.

Limited weight of personal mitigating circumstances

99 Dr Wong raised various points in his mitigation plea, including his early plea of guilt, the fact that he had settled a civil suit with the patient's estate and next-of-kin, and his clean record prior to 2009. However, bearing in mind the severity of Dr Wong's misconduct and the compelling public interest in imposing the harshest punishment on him, these personal mitigating circumstances ultimately carry no weight in the sentencing analysis.

100 In *Ang Peng Tiam* at [102], we accepted that "evidence of an offender's long and unblemished record may be regarded as a mitigating factor of *modest* weight if, and to the extent, such evidence fairly allows the court to infer that

the offender's actions in committing the offence were 'out of character' and that therefore, he is unlikely to re-offend [emphasis in original]". This principle was relied upon by the DT when taking into account Dr Wong's clean track record. However, Dr Wong was only in his early thirties at the time of the offence and even if we took into account his record after the offence, Dr Wong's record is simply not comparable to that of the senior doctor in *Ang Peng Tiam* who had maintained an otherwise unblemished track record over more than 30 years of practice (at [105]). We also stressed in *Ang Peng Tiam* at [103] that the mitigating value of a clean record "will be readily displaced" in the face of other sentencing considerations such as general deterrence.

101 An early plea of guilt may generally be regarded as a sign of remorse and might warrant a reduction in the sentence received by the offender. However, because the evidence of Dr Wong's misconduct was so overwhelming and his conviction for the charge was inevitable, we do not regard his guilty plea as a sign of contrition. We also agree with the SMC's submission that no mitigating value ought to be attached to the settlement of civil liability as that concerned entirely separate proceedings.

102 Dr Wong also contends that the DT ought to have extended a more substantial sentencing discount to account for the SMC's delay in commencing disciplinary proceedings against him. In *Ang Peng Tiam*, we examined the relevance of delay in the institution of disciplinary proceedings and held at [109]–[118] that the court may exercise its discretion to give a sentencing discount upon consideration of the following factors:

(a) First, there must have been an inordinate delay in the institution or prosecution of proceedings against the offender. This is to be assessed in the context of the nature of the investigations.

(b) Second, the delay must not have been occasioned by the offender.

(c) Third, the offender must have suffered prejudice.

(d) Finally, the underlying rationale of fairness to the offender which justifies the imposition of a sentencing discount in cases of delay may, on occasion, be offset or outweighed by the public interest which demands the imposition of a heavier penalty.

103 We accept that the first three requirements have been met. The Notices of Inquiry were only received by Dr Wong and Dr Zhu in February 2017, more than seven years after the acts of misconduct had taken place in December 2009 and more than three years after the doctors had received the Notices of Complaint in November 2013. In *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Jen Shek Wei*") and *Ang Peng Tiam*, we held that delays of similar lengths were inordinate notwithstanding that time was needed to obtain expert opinions or to frame the charges, which were matters that the SMC also raised in the case at hand. It is undisputed that the delay was not occasioned by either Dr Wong and Dr Zhu, and as a matter of natural inference, the doctors would have suffered prejudice in the form of anxiety and distress as a result of the proceedings hanging over them for such a prolonged period: see *Jen Shek Wei* at [167] and *Ang Peng Tiam* at [123].

104 But in spite of the considerable delay in the proceedings, we decline to place any weight on this in the present case on the basis of the fourth factor we articulated in *Ang Peng Tiam*. As we have explained and reiterated at [26] and [99] above in respect of personal mitigating circumstances, any justification for a sentencing discount in cases of delay must be carefully considered against the public interest. In view of the gravity of Dr Wong's misconduct, the need to

ensure fairness to the individual offender in this case is entirely overridden by the wider considerations of general deterrence and the need to uphold the standing of the medical profession.

105 For completeness, we address Dr Wong's argument that in determining an adequate deterrent sentence, the DT should have taken into account the very low risk of him reoffending because his accreditation to perform liposuction procedures has been revoked and he can no longer administer Propofol pursuant to the 2014 "Guidelines on Safe Sedation Practice for Non-Anaesthesiologists". In our judgment, this is misconceived because it rests on an artificially narrow conception of the deterrent purpose of the sentence by ignoring the possibility of Dr Wong committing similar (even if not identical) acts of professional misconduct, such as performing other medical procedures despite lacking the requisite training and failing to monitor his patients with the requisite standard of care. Moreover, it also fails to account for the need to ensure not just specific deterrence but *general* deterrence for other like-minded members of the medical profession – which, as we have already noted, is a key sentencing consideration.

106 For these reasons, we are satisfied that the appropriate order is to strike Dr Wong off the register of approved medical practitioners under s 53(2)(*a*) of the Medical Registration Act. In our judgment, the relevant sentencing principles of general and specific deterrence, as well as the need to protect public confidence and uphold the standing of the medical profession, strongly justify the harshest possible sentence for Dr Wong. Having regard to his grossly improper conduct and the gravity of the harm that was occasioned, even a three-year term of suspension would be inadequate to safeguard the public's trust in the medical profession and to deter similar misconduct in the future. We therefore find that the seriousness of Dr Wong's misconduct warrants striking him off the register of medical practitioners.

Dr Zhu (OS 2)

The parties' cases

107 The SMC's arguments in its appeal against Dr Zhu's sentence are broadly similar to the ones it raised in Dr Wong's case: that the DT did not place sufficient weight on the severity of the consequences suffered by the patient; that the DT failed to appreciate the need for the sentence to have a strong deterrent effect; and that the DT placed excessive weight on mitigating factors such as Dr Zhu's early plea of guilt. According to the SMC, Dr Zhu's six-month suspension term was manifestly inadequate and should be increased to two years because of the severe aggravating factors present. In response, Dr Zhu contends that the DT did not err and that the sentence it ordered was in line with her degree of culpability and the sentencing precedents.

Our decision

108 The facts relating to Dr Zhu are largely similar to those for Dr Wong, save for a few material differences which we highlight here:

(a) Dr Wong was the doctor *in charge* of the patient's liposuction procedure, and Dr Zhu was only tasked to assist in the procedure. She was called into the procedure room just prior to the commencement of the liposuction and acted under the direction of Dr Wong at all times (see [5] above).

(b) It was Dr Wong who alone inflicted the multiple intestinal puncture wounds on the patient. Dr Zhu was not responsible for these injuries (see [11] above).

(c) At the time when Dr Zhu left the procedure room, Dr Wong was still closing the patient's surgical wounds. She had Dr Wong's permission to leave the room and did not know that he would then leave the patient unattended (see [12] above).

(d) Unlike Dr Wong, Dr Zhu did not make any false statements to the A&E doctors to cover up the fact that Propofol had been administered to the patient, or act dishonestly in any other way (see [13] above).

109 Notwithstanding these facts, Dr Zhu's misconduct was nonetheless of a serious nature. She agreed to administer Propofol to the patient even though she knew that neither she nor Dr Wong was qualified to do so as they were not anaesthetists or intensivists (see [8] above). Due to their inexperience, both doctors ended up sedating the patient in a way that was improper, dangerous and excessive. Dr Zhu did not know or realise the consequences of administering Propofol, did not appreciate the relevant danger signs, and as a result of this, did not take steps to ensure the proper supervision and monitoring of the patient during and after the procedure. This ultimately caused the patient's death.

110 Applying again the same sentencing approach we laid down at [29]–[44] above, we evaluate the seriousness of the offence by considering the utmost severity of the harm occasioned against Dr Zhu's substantial degree of culpability based on the facts highlighted above. We accept that her misconduct was not as directly related to the patient's death as was the case with Dr Wong; we also accept that she was less culpable. In all the circumstances, we assess her culpability as "medium". We also consider that while her misconduct was causally connected to the patient's death as we have explained in the previous

paragraph, it was not in the direct way that Dr Wong's misconduct was causally connected. Taking these considerations into account, we find that the DT's sentence of six months' suspension was manifestly inadequate and the term of suspension should be significantly longer.

111 For the same reasons as we have stated in respect of Dr Wong, Dr Zhu's personal mitigating circumstances such as her early plea of guilt and the inordinate delay in the proceedings are overridden by the public interest in upholding public confidence in the medical profession. The sentence to be imposed on Dr Zhu must also serve as a strong deterrent to other junior doctors faced with the wholly improper actions of their seniors.

112 In these circumstances, we think that a sentence of 18 months' suspension from practice is appropriate for Dr Zhu and is more compatible with the sentence we have given to Dr Wong, having regard to the relative culpability of each doctor and the extent of their misconduct.

Conclusion

113 For these reasons, we allow both appeals of the SMC in OS 2 and OS 3, and dismiss Dr Wong's appeal in OS 1.

(a) We order that Dr Wong be struck off the register of approved medical practitioners. Of the orders made against Dr Wong by the DT below, we maintain only the order that Dr Wong pay the costs of the DT proceedings, as the remaining orders for suspension, censure and a written undertaking are no longer relevant or necessary.

(b) We increase Dr Zhu's term of suspension to 18 months. The DT's orders that Dr Zhu be censured, provide a written undertaking, and pay the costs of the DT proceedings, shall stand.

114 Aside from our orders in these appeals, we have directed that this case be reported to the Public Prosecutor so that the doctors involved may be investigated for any relevant criminal offences that may have been committed including that of causing death by rash or negligent act under s 304A of the Penal Code. In so doing, we refer to the decision of the House of Lords in *R v Adomako* [1994] 3 WLR 288, which involved an anaesthetist's failure to monitor the patient under his care which led to the patient's death. In that case, the House of Lords affirmed the anaesthetist's conviction for the offence of gross negligence manslaughter. While we express no views at all on whether any criminal offence is disclosed on the facts before us, we consider it to be in the public interest that the matter be investigated.

115 Unless the parties are able to come to an agreement as to the costs of these appeals, they are to furnish brief written submissions (limited to seven pages) on the appropriate costs order within 14 days of this judgment.

Sundaresh Menon Chief Justice	Andrew Phang Boon Leong Judge of Appeal	Judith Prakash Judge of Appeal

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